

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11503

CERTIFICATE OF DEATH

11508

1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>	
c. LENGTH OF STAY IN lb <b>10 DAYS</b>		d. STREET ADDRESS <b>18, 1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. MARY'S HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY ALBERTA BLACKISTONE</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>25</b> Year <b>19 67</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 31, 1905</b>
9. AGE (In years last birthday) yrs. <b>61</b>		IF UNDER 1 YEAR Months <b>18</b> Days <b>11</b> Hours <b>11</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM GOUGH</b>		14. MOTHER'S MAIDEN NAME <b>SADIE HAYDEN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>LUCIOUS BLACKISTONE</b>		Address <b>LEONARDTOWN, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolus</b> DUE TO <b>8 days</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Thrombophlebitis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 20, 1967</b> , to <b>Aug 25, 1967</b> , that (I) (we) last saw the deceased alive on <b>Aug 25, 1967</b> , and that death occurred at <b>10P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>W.D. Boyd</b>		22b. DATE SIGNED <b>8/27/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM D. BOYD M. D.</b>		22d. ADDRESS <b>LEONARDTOWN, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>Aug. 28, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. JOHNS CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>8 HOLLYWOOD, MARYLAND</b>
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>		25a. REC'D BY REGISTRAR <b>AUG 31 1967</b>	
ADDRESS <b>LEONARDTOWN, MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11504

11509

FOR STATE  
HEALTH DEPT

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Patuxent River</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>USNAS, Patuxent River</b>	
c. LENGTH OF STAY IN 1b <b>2 yrs.</b>		d. STREET ADDRESS <b>RR-2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Station Hospital, USNAS</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>David Joseph Borgie</b>		4. DATE OF DEATH <b>August 28, 1967</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 10, 1942</b>
9. AGE (In years lost birthday) <b>25 yrs.</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>18</b> Hours <b>18</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Aviation AntiSub Warfare Tech. U.S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Illinois</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Wilfred Borgie</b>		14. MOTHER'S MAIDEN NAME <b>Waneta Bolite</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes JUN 1960-1967</b>		16. SOCIAL SECURITY NO. <b>351 34 1071</b>	
17. INFORMANT <b>Official U. S. Navy Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation due to drowning.</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>ATTEMPTED TO SWIM TROY DISABLED BOAT TO SHORE</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Asphyxiation due to drowning.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>3:00</b> <b>AUG 28, 1967</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> <b>Chesapeake Bay</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Scotland, St. Mary's, Md.</b>		20f. (City or town) (County) (State) <b>Proximal to Point Look In</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>C. F. MacCarthy, M.D. (LT, MC, USN)</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>WILLIAM D. BOYD M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANSIT</b>		23b. DATE THEREOF <b>AUG 29, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>JOHN M. WILCH</b>		23d. LOCATION (City or Town) (County) (State) <b>NOKOMIS ILL.</b>	
25a. REC'D BY REGISTRAR DATE <b>AUG 31 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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FOR STATE  
HEALTH DEPT.

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VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11505

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11510

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PATUXENT RIVER</b> c. LENGTH OF STAY IN 1b <b>18.1</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>ST. MARYS</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>172 CHINLEE DR.</b> d. STREET ADDRESS <b>LEXINGTON PARK</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EDWARD R. BRADLEY</b>		4. DATE OF DEATH Month <b>August</b> Day <b>25</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/28/1943</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PARACHUTE RIGGER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>USN</b>	9. AGE (In years lost birthday) <b>24</b> IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <b>TEXAS</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>BOBBIE BRADLEY</b>		14. MOTHER'S MAIDEN NAME <b>IRENE SAMPLE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES 1962-1967</b>		16. SOCIAL SECURITY NO. <b>464 68 0300</b>	
17. INFORMANT <b>OFFICIAL NAVY RECORDS - SAME AS 1B</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>981X</b> IMMEDIATE CAUSE (a) <b>Gunshot wound of chest</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Subject was shot in the chest</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>1:50</b> <b>8 25</b> 19 <b>67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Tavern</b> 20f. (City or town) (County) (State) <b>Hermansville Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b>		22. DATE SIGNED <b>August 25, 1967</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANSIT</b>		23b. DATE THEREOF <b>8/27/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>JOHN M. WELCH - LEONARDTOWN, MD.</b>		23d. LOCATION (City or town) (County) (State) <b>AMARILLO, TEXAS</b>	
24. FUNERAL DIRECTOR <b>John M. Welch</b>		25a. REC'D BY REGISTRAR <b>AUG 30 1967</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL PINEY POINT</b>		c. LENGTH OF STAY IN lb <b>LIFE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CLARENCE A. BRISCOE</b>		4. DATE OF DEATH Month Day Year <b>AUGUST 27, 1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 8, 1896</b>
9. AGE (In years lost birthday) yrs. <b>70</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMING</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM BRISCOE</b>		14. MOTHER'S MAIDEN NAME <b>CAROLINE WILSON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>570-01-4703</b>	
17. INFORMANT <b>DENICE M. DICKENS</b>		Address <b>2108-38TH. ST. S.E. WASH. D.C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Coronary occlusion</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>W. D. Boyd M.D.</b>		22. DATE SIGNED <b>8-29-67</b>	
EXAMINER'S NAME (Type) <b>WILLIAM D. BOYD M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>AUG. 31, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. GEORGE CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>VALLEY LEE, ST. MARY'S, MD.</b>
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>AUG 31 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1. LANE, WILLIAM, BIRMINGHAM, ALABAMA

ARRIVE: APR. 21, 1901 ST. GEORGE JEWETRY

VALLEY VIEW, ST. MARK, MD.

JOHN C. LEWIS, JR.

x

THE UNIVERSITY OF CHICAGO  
CHICAGO, ILL.

DEPARTMENT OF CHEMISTRY, DIVISION OF PHYSICS

WILLIAM BRIDGES

CAROLINE WILSON

CHICAGO

CHICAGO, ILL.

CHICAGO

CHICAGO, ILL.

TO

CLARENCE A.

BRIDGES

AUGUST

1901

LOCAL FIVE FIVE

RURAL

POINT

ST. MARK

CHICAGO

ST. MARK

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

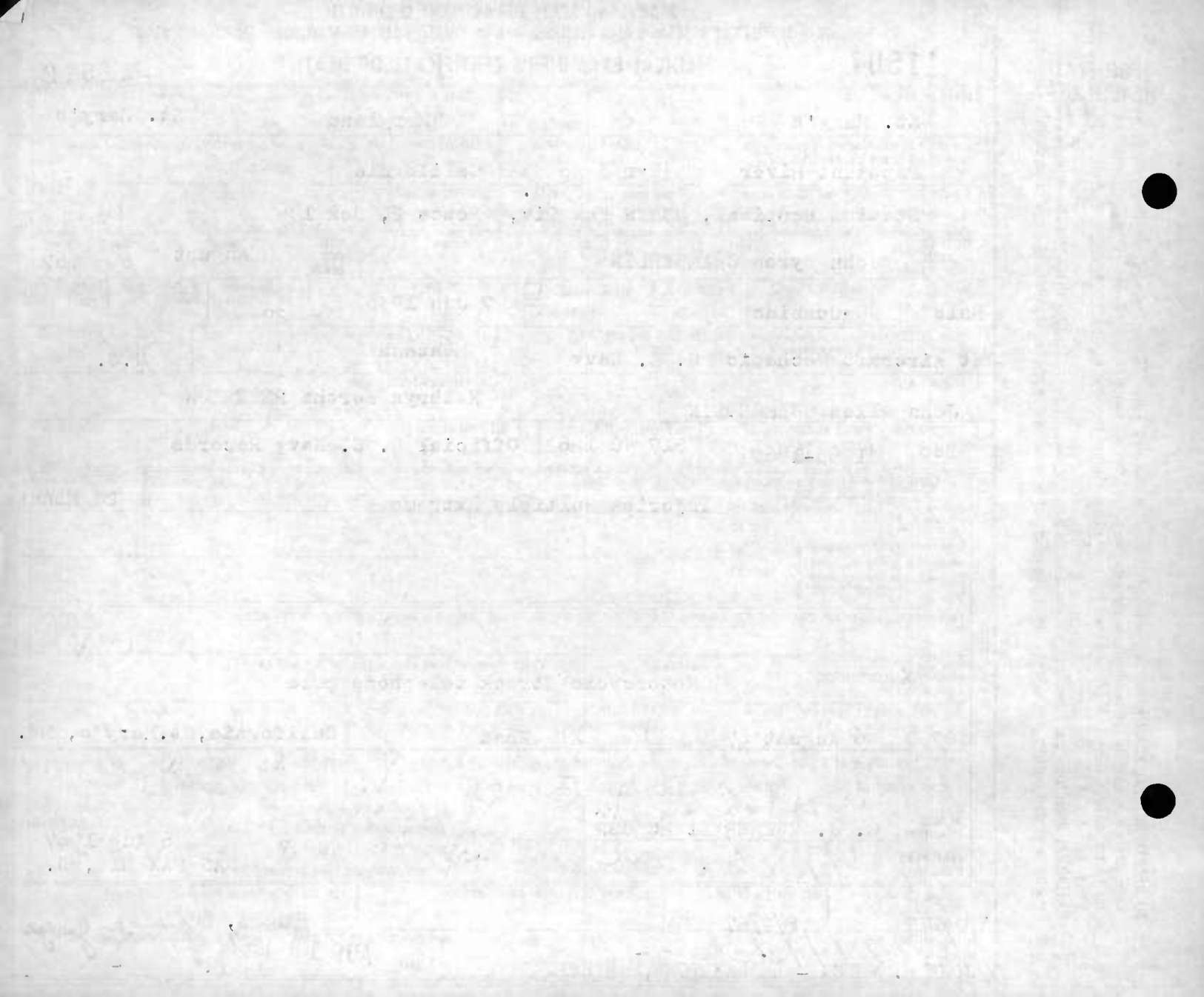
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11507

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11512

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Patuxent River</b>		c. LENGTH OF STAY IN 1b <b>2yr 3 mo</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>California</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Station Hospital, USNAS Pax Riv,</b>		d. STREET ADDRESS <b>Route 2, Box 194</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Byron</b> Last <b>CHAMBERLIN</b>		4. DATE OF DEATH Month <b>August</b> Day <b>6</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7 Jan 1938</b>
9. AGE (In years last birthday) <b>29</b> yrs.		IF UNDER 1 YEAR Months <b>29</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Jet Aircraft Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>	11. BIRTHPLACE (State or foreign country) <b>Montana</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>John Allen CHAMBERLIN</b>	
14. MOTHER'S MAIDEN NAME <b>Kathryn Bertha PETERSON</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>1955-1967</b>	
16. SOCIAL SECURITY NO. <b>517 40 1262</b>		17. INFORMANT Address <b>Official U. S. Navy Records</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>8214</b> IMMEDIATE CAUSE (a) <b>Injuries Multiple Extreme</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>20 Minute</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Motorcycle Struck telephone pole</b>		20c. TIME OF INJURY Month, Day, Year Hour <b>0750</b> a.m. <b>6</b> p.m. <b>August 19 67</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Road</b>	
20f. (City or town) (County) (State) <b>California, St. Mary's, Md.</b>		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>G. J. VUKMER Lt MC USN</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>J. J. Chamberlin</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>6 Aug 1967</b>		Address (Street, city, town, or county) <b>NAS PAX RIV, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANSIT</b>		23b. DATE THEREOF <b>8/9/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>JOHN M. WELCH - LEONARDTOWN, MARYLAND</b>		23d. LOCATION (City or Town) (County) (State) <b>HELENA, MONTANA</b>	
24. FUNERAL DIRECTOR <b>John M. Welch</b>		25a. REC'D BY REGISTRAR <b>HELENA, MONTANA</b>	
ADDRESS <b>JOHN M. WELCH - LEONARDTOWN, MARYLAND</b>		DATE <b>AUG 10 1967</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b> c. LENGTH OF STAY IN 1b <b>Leonardtown</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Mary's Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b> d. STREET ADDRESS <b>5 Lincoln Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>BABY GIRL</b>			First <b>Courtney</b>		Middle		Last		4. DATE OF DEATH Month <b>August</b> Day <b>21</b> Year <b>1967</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 21 1967</b>		9. AGE (In years last birthday) <b>2</b> yrs. <b>2</b> months <b>2</b> days <b>2</b> hours <b>2</b> min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>James (Unknown) Smith</b>					14. MOTHER'S MAIDEN NAME <b>Mary Frances Courtney</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <b>Mother</b> Address <b>Lexington Park, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>776X</b> DUE TO <b>Prematurity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <b>9/21/67</b> Hour a.m. <b>19</b> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>9/21/67</b> to <b>9/21/67</b> that (I) ( <del>we</del> ) last saw the deceased alive on <b>8/21/67</b> , and that death occurred at <b>9/21/67</b> AM, from the causes and on the date stated above. 22a. SIGNATURE <b>James P. Jarboe</b> 22b. DATE SIGNED <b>8/22/67</b> 22c. PHYSICIAN'S NAME (Type) <b>James P. Jarboe M.D.</b> 22d. ADDRESS <b>Great Mills, Maryland</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8/23/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. JOSEPHS CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>MORGANZA, MD.</b>				
24. FUNERAL DIRECTOR <b>Robinson's</b> <b>JOHN M. WELCH</b>				ADDRESS <b>Leonardtown, Md.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		
DATE <b>AUG 25 1967</b>										

7-263019

STATE DEPARTMENT OF HEALTH  
DIVISION OF PUBLIC HEALTH  
BUREAU OF VITAL STATISTICS

DATE OF BIRTH: 10/10/1907  
PLACE OF BIRTH: [illegible]

EDUCATION: [illegible]

RELIGION: [illegible]

INDUSTRY: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF INTERMENT: [illegible]

PLACE OF INTERMENT: [illegible]

NAME OF FUNERAL HOME: [illegible]

NAME OF MINISTER: [illegible]

NAME OF CHURCH: [illegible]

NAME OF CEMETERY: [illegible]

NAME OF FUNERAL HOME: [illegible]

NAME OF MINISTER: [illegible]

NAME OF CHURCH: [illegible]

NAME OF CEMETERY: [illegible]

NAME OF FUNERAL HOME: [illegible]

NAME OF MINISTER: [illegible]

NAME OF CHURCH: [illegible]

NAME OF CEMETERY: [illegible]

NAME OF FUNERAL HOME: [illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11509

## CERTIFICATE OF DEATH

11514

1. PLACE OF DEATH a. COUNTY <b>ST. MARYS</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL MECHANICSVILLE</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARYS</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL MECHANICSVILLE</b> d. STREET ADDRESS <b>RT. #1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GEORGE M. FENWICK</b>		4. DATE OF DEATH Month <b>AUG.</b> Day <b>9</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 13, 1916</b>
9. AGE (In years last birthday) <b>50</b> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>HARRY FENWICK</b>		14. MOTHER'S MAIDEN NAME <b>DELIA BUTLER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES WWII</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>HARRY FENWICK - SAME AS #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>5810 Simon Lage, esophageal varices</b> Conditions, if any, which gave rise to immediate cause (b) <b>Chronic liver</b> (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr 3 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1, 1960</b> , to <b>Aug 8, 1967</b> , that (I) (we) last saw the deceased alive on <b>Aug 7, 1967</b> , and that death occurred at <b>6 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>J. Roy Guyther</b> M.D.		22b. DATE SIGNED <b>8/11/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. ROY GUYTHER M.D.</b>		22d. ADDRESS <b>MECHANICSVILLE, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>8/12/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. JOSEPHS CEMETERY</b>	23d. LOCATION (City, town or county) (State) <b>MORGANZA, MD.</b>
24. BURIAL DIRECTOR'S SIGNATURE <b>John M. Welch</b>		25a. REC'D BY REGISTRAR <b>John M. Welch</b> 25b. REGISTRAR'S SIGNATURE <b>John M. Welch</b>	
24. ADDRESS <b>JOHN M. WELCH - LEONARDTOWN, MD.</b>		DATE <b>AUG 14 1967</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF TEXAS  
COUNTY OF DALLAS

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

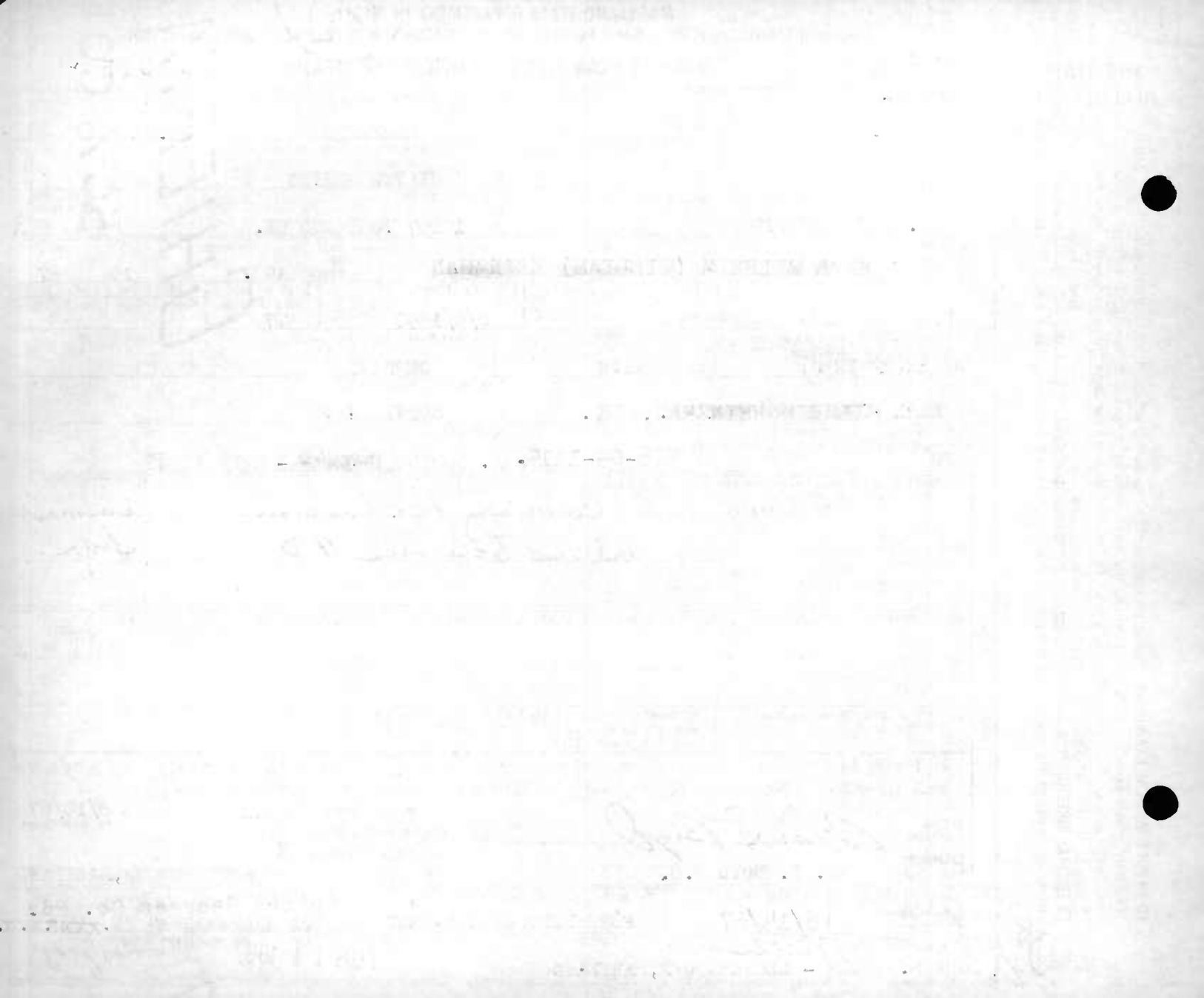
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11510

11515

1. PLACE OF DEATH a. COUNTY <b>ST. MARYS</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARYS</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. MARYS HOSPITAL</b>			d. STREET ADDRESS <b>10107 PORTLAND PL.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>KARL WILHELM (WILLIAM) HEINZMAN</b>			4. DATE OF DEATH <b>AUG.</b> Month <b>10</b> Day <b>19</b> Year <b>67</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>8/6/1890</b>		9. AGE (In years lost birthday) <b>77</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BAKER (RETIRED)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BAKING</b>		11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>KARL WILHELM HEINZMAN, SR.</b>		
14. MOTHER'S MAIDEN NAME <b>SOPHIA HAUG</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>578-09-1115</b>			17. INFORMANT <b>MRS. LOUISE HEINZMAN SAME AS #2</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis HD</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>immed</b> <b>5 yr</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Wm D Boyd</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>WM. D. BOYD M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <b>LEONARDTOWN, MARYLAND</b>					
23a. BURIAL, CREMATION, or REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8/14/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CEMETERY</b>	
23d. LOCATION (City or town) (County) (State) <b>Prince Georges Co. Md.</b>		23e. LOCATION (City or town) (County) (State) <b>3201 BLADENSBURG RD. WASH DC</b>			
24. FUNERAL DIRECTOR <b>John M. Welch</b>		ADDRESS <b>LEONARDTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 14 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11516

11511

1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>		c. LENGTH OF STAY IN 1b <b>9 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEXINGTON PARK, 18.1</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. MARY'S HOSPITAL</b>				d. STREET ADDRESS <b>Box 232</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>VERNETTE AGNES HOPEWELL</b>				4. DATE OF DEATH Month Day Year <b>AUGUST 26, 1967</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 27, 1926</b>	9. AGE (In years lost birthday) yrs. <b>40</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NURSE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>CALIFORNIA MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL KANE</b>				14. MOTHER'S MAIDEN NAME <b>LAURA BEALE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>JEROME R. HOPEWELL SAME AS # 2 ABOVE</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>crabclawing of blood</b> 578X DUE TO <b>continuous gangrene of</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>small intestine</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3 fractured ribs</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8.17</b> , 19 <b>67</b> , to <b>8.26</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>8.26</b> , 19 <b>67</b> , and that death occurred at <b>7:54</b> AM, from causes and on the date stated above.							
22a. SIGNATURE <b>Michael Barbarich</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8.29.67</b>	
22c. PHYSICIAN'S NAME (Type) <b>MICHAEL BARBARICH M. D.</b>				22d. ADDRESS <b>LEXINGTON PARK, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>AUG. 29, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HOLY FACE CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>GREAT MILLS, ST. MARY'S, MD.</b>	
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND</b>				25a. REC'D BY REGISTRAR <b>AUG 31 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF THE ARMY

ST. LOUIS, MO.

MARYLAND

WASH.

ST. LOUIS, MO.

LEXINGTON PARK, MD.

9 DAYS

LEXINGTON PARK, MD.

ST. LOUIS, MO.

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THE ARMY

WASH.

WASH.

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ABOUT 27,000

ABOUT 27,000

LEXINGTON PARK, MD.

LEXINGTON PARK, MD.

LEXINGTON PARK, MD.

LEXINGTON PARK, MD.

*Handwritten notes:*  
The following is a list of the names of the persons who were present at the meeting held at Lexington Park, Maryland, on the 27th of August, 1900.  
The names are as follows:  
1. Mr. J. H. ...  
2. Mr. ...  
3. Mr. ...  
4. Mr. ...  
5. Mr. ...  
6. Mr. ...  
7. Mr. ...  
8. Mr. ...  
9. Mr. ...  
10. Mr. ...  
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14. Mr. ...  
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88. Mr. ...  
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91. Mr. ...  
92. Mr. ...  
93. Mr. ...  
94. Mr. ...  
95. Mr. ...  
96. Mr. ...  
97. Mr. ...  
98. Mr. ...  
99. Mr. ...  
100. Mr. ...

LEXINGTON PARK, MD.

LEXINGTON PARK, MD.

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

ST. LOUIS, MO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11512

CERTIFICATE OF DEATH

11517

1. PLACE OF DEATH a. COUNTY <u>ST. MARY'S</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ST. MARY'S</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MARY'S CITY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MARY'S CITY</u> 18.1	
c. LENGTH OF STAY IN 1b <u>LIFE</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JEANNETTE BROME HOWARD</u>		4. DATE OF DEATH Month Day Year <u>AUGUST 27, 19 67</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 21, 1881</u>
9. AGE (In years lost birthday) yrs. <u>85</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>ST. MARY'S CITY, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES THOMAS BROME</u>		14. MOTHER'S MAIDEN NAME <u>ELIZA EMALINE THOMAS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>J. SPENCE HOWARD JR. SAME AS # 2 ABOVE</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac Failure</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 1<sup>st</sup></u> , 19 <u>58</u> , to <u>August 27, 19 67</u> , that (I) (we) last saw the deceased alive on <u>August 27, 19 67</u> , and that death occurred at <u>9 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Charles Greenwell</u>		22b. DATE SIGNED <u>8/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>CHARLES GREENWELL M. D.</u>		22d. ADDRESS <u>LEONARDTOWN, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>AUG. 30, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>TRINITY EPISCOPAL CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>ST. MARY'S CITY, MARYLAND</u>
24. FUNERAL DIRECTOR <u>W. CLARKE MATTINGLEY</u>		25a. REC'D BY REGISTRAR <u>AUG 31 1967</u>	
ADDRESS <u>LEONARDTOWN, MARYLAND</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

RECEIVED BY THE ATTORNEY GENERAL'S OFFICE

STATE OF MARYLAND

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MARYLAND

ST. MARY'S

ST. MARY'S CITY

1881

ST. MARY'S CITY

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AUGUST

HOWARD

BRIDGE

DEPARTMENT

1881

1881, 1882

1881

WHITE

WHITE

ST. MARY'S CITY, M.

RECEIVED BY THE ATTORNEY GENERAL'S OFFICE

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RECEIVED BY THE ATTORNEY GENERAL'S OFFICE

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

11513

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11518

1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>VIRGINIA</b> b. COUNTY <b>ARLINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL AVENUE</b>		c. LENGTH OF STAY IN lb <b>2 WEEKS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TDWN (If outside corporate limits, write RURAL and give nearest town) <b>ARLINGTON</b> 83.3	
		d. STREET ADDRESS <b>2804 - 8TH STREET SOUTH</b>	
3. NAME OF DECEASED (Type or print) First <b>PAUL</b> Middle <b>E</b> Last <b>KECKLER</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>17</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 20, 1895</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CIVIL SERVICE</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <b>71</b> IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SIMON KECKLER</b>		14. MOTHER'S MAIDEN NAME <b>SUSAN N. MOTE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>WILLIAM B. KECKLER</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4301 Coronary Occlusion</b> DUE TO (b) <b>Coronary Atherosclerosis</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>59 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>P. J. BEAN</b>		M.D. <b>P. J. BEAN</b>	
EXAMINER'S NAME (Type) <b>P. J. BEAN M. D.</b>		22. DATE SIGNED <b>AUG. 17, 1967</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		23b. DATE THEREOF <b>AUG. 19, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>SUITLAND, PRINCE GEORGE, MD.</b>	
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>		ADDRESS <b>LEONARDTOWN, MARYLAND</b>	
25a. RECD BY REGISTRAR <b>AUG 21 1967</b>		25b. REGISTRAR'S SIGNATURE <b>W. Clarke Mattingley</b>	

27 MAY 1988

NOTE 1

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11514

## CERTIFICATE OF DEATH

11519

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>St. Mary's</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>St. Mary's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Leonardtoun</i>		c. LENGTH OF STAY IN 1b <i>17 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>St. Mary's Hospital</i>		d. STREET ADDRESS <i>Drayden Rural</i>	
3. NAME OF DECEASED (Type or print) First <i>Joseph</i> Middle <i>Ambrose</i> Last <i>Lynn</i>		4. DATE OF DEATH Month <i>August</i> Day <i>5</i> Year <i>19 67</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 21, 1894</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>72</i> yrs.
13. FATHER'S NAME <i>Stanton Warren Lynn</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Charles Co., Maryland</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
14. MOTHER'S MAIDEN NAME <i>Alice Rebecca Turner</i>		17. INFORMANT <i>Mrs. Dona Goode, Maddox, Maryland</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4221 Cardiac Failure</i> DUE TO (b) <i>Cardio-vascular disease</i> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>11/15</i> , 19 <i>64</i> , to <i>8/5</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>8/5</i> , 19 <i>65</i> and that death occurred at <i>9:45</i> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Charles Greenwell</i> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Charles Greenwell, M.D.</i>		22d. ADDRESS <i>Leonardtoun, Maryland.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>8/7/67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Bladensburg, Maryland</i>
24. FUNERAL DIRECTOR <i>W. Clarke Mattingley</i>		25a. REC'D BY REGISTRAR DATE <i>AUG 9 1967</i>	
ADDRESS <i>Leonardtoun, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
11515					11520				
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>			c. LENGTH OF STAY IN 1b <b>6 YEARS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b> 181				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2 CHURCH STREET</b>					d. STREET ADDRESS <b>2 CHURCH STREET</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>VERA MAY PONT</b>					4. DATE OF DEATH Month Day Year <b>AUGUST 26, 1967</b>				
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JAN. 16, 1893</b>		9. AGE (In years last birthday) yrs. <b>74</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>WEST MAITLAND AUSTRALIA</b>			12. CITIZEN OF WHAT COUNTRY? <b>AUSTRALIAN</b>	
13. FATHER'S NAME <b>ARTHUR WILLIAM DAUNT</b>					14. MOTHER'S MAIDEN NAME <b>LAURA JOHNSON</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>JOYCE A. MATTINGLY</b> Address <b>LEONARDTOWN, MD.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> (c) <b>10y1.</b>								INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>May 19 1964</b> , to <b>Aug 14, 1967</b> , that (I) (we) last saw the deceased alive on <b>Aug 14, 1967</b> , and that death occurred at <b>4:14 A.M.</b> from causes and on the date stated above.									
22a. SIGNATURE <b>John F. Fenwick</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>8/26/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN F. FENWICK M. D.</b>					22d. ADDRESS <b>LEONARDTOWN, MARYLAND</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		23b. DATE THEREOF <b>AUG. 28, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CREMATORY</b>			23d. LOCATION (City or Town) (County) (State) <b>SUITLAND, PRINCE GEORGE MD.</b>		
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLY LEONARDTOWN, MARYLAND</b>					25a. REC'D BY REGISTRAR <b>AUG 31 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

STATE OF MARYLAND

ST. MARY'S

MARYLAND

ST. MARY'S

LEONARDTOWN

LEONARDTOWN

LEONARDTOWN

CHURCH STREET

CHURCH STREET

VERA

RAY

RAY

RAY

WHITE

WHITE

WHITE

MOORE

MOORE

MOORE

LEONARDTOWN

LEONARDTOWN

LEONARDTOWN, MARYLAND

*Witnessed by*

*John F. Fenton*

LEONARDTOWN, MARYLAND

JOHN F. FENTON, J. D.

CHURCH STREET, LEONARDTOWN, MARYLAND

LEONARDTOWN, MARYLAND

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

11516

11521

1. PLACE OF DEATH a. COUNTY <b>ST. MARYS</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b> c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARYS</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>BROTHER AMADEUS C.F.X. (REUTER)</b>			4. DATE OF DEATH <b>AUG. 31 19 67</b>				
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/21/1894</b>		9. AGE (In years last birthday) <b>73</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TEACHER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RELIGIOUS</b>		11. BIRTHPLACE (County & State, or foreign country) <b>OHIO</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>GEORGE REUTER</b>			14. MOTHER'S MAIDEN NAME <b>ROSE BURBINK</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218 54 5582</b>		17. INFORMANT <b>BROTHER SCOTT * SAME AS #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>4201 Myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (b) <b>Hypertensive cardiovascular disease</b> (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH <b>few minutes</b>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>8/10/67</b> , 19 <b>67</b> , to <b>9/2/67</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>9/2/67</b> , and that death occurred at <b>9/2/67</b> , M, from the causes and on the date stated above.							
22a. SIGNATURE <b>S. Laurel, M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9/2/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>S. LAUREL M.D.</b>		22d. ADDRESS <b>LEONARDTOWN, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>9/4/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART NOVITIATE</b>		23d. LOCATION (City, town or county) (State) <b>LEONARDTOWN, MARYLAND</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN M. WELCH - LEONARDTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>SEP 6 1967</b>		25b. REGISTRAR'S SIGNATURE <b>John M. Welch</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

21

— 1992

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11517						11522					
1. PLACE OF DEATH a. COUNTY <b>ST. MARYS</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b> c. LENGTH OF STAY IN 1b <b>ST. MARYS HOSPITAL</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARYS</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - GREAT MILLS</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>SARAH</b> First <b>CATHERINE</b> Middle <b>SANNER</b> Last			4. DATE OF DEATH <b>AUG.</b> Month <b>24</b> Day <b>1967</b> Year								
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/2/1889</b>		9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>				11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WM. LEE BISCOE</b>						14. MOTHER'S MAIDEN NAME <b>MARY P. BISCOE</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>215 56 9870</b>		17. INFORMANT <b>WM. SANNER - SAME AS #2</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>A.V. Heart Block</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Coronary sclerosis</b> a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus</b>										INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b> <b>5 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>June</b> 1967 to <b>Aug. 24</b> , 1967, that (I) (we) last saw the deceased alive on <b>Aug. 24</b> , 1967, and that death occurred at <b>4 P.</b> M., from the causes and on the date stated above.											
22a. SIGNATURE <b>P.J. BEAN M.D.</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>GREAT MILLS, MARYLAND</b>		22b. DATE SIGNED <b>8/26/67</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8/27/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>TRINITY EPISCOPAL</b>				23d. LOCATION (City, town or county) (State) <b>ST. MARYS CITY, MARYLAND</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Welch</b> <b>JOHN M. WELCH - LEONARDTOWN, MARYLAND</b>						25a. REC'D BY REGISTRAR <b>AUG 30 1967</b>		25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>			

13322

STATE OF OHIO

Aug 10 1961

11518

## CERTIFICATE OF DEATH

11523

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Patuxent River</u>			c. LENGTH OF STAY IN 1b <u>Newborn</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lexington Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U.S. Naval Air Station Hospital</u>				d. STREET ADDRESS <u>603 Chinlee Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lisa Marie Schaefer</u>				4. DATE OF DEATH Month Day Year <u>August 17 1967</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cau</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 15, 1967</u>		
9. AGE (In years last birthday) yrs. <u>2</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>2</u>		IF UNDER 24 HRS. Hours Min. <u>2</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>St. Mary's Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Schaefer</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Mary Draper</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Edward Schaefer</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary hemorrhage</u> <u>7715</u> DUE TO <u>Hemorrhagis diathesis of newborn</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Prematurity and hyaline disease</u> (c) <u>Prematurity and hyaline disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>45 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>15 Aug</u> , 19 <u>67</u> , to <u>17 Aug</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>17 Aug</u> , 19 <u>67</u> , and that death occurred at <u>      </u> M, from causes and on the date stated above.								
22a. SIGNATURE <u>James R. Abel</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>17 Aug 1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>JAMES R. ABEL</u>				22d. ADDRESS <u>Same as # 1</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/22/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>ARLINGTON, VIRGINIA</u>		
24. FUNERAL DIRECTOR <u>JOHN M. WELCH</u>				25a. REC'D BY REGISTRAR <u>AUG 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

2157

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11519

CERTIFICATE OF DEATH

11524

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MECHANICSVILLE</u>	
c. LENGTH OF STAY IN 1b <u>1 HOUR</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Mary's Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>WILLIAM MILTON SHORTER</u>		4. DATE OF DEATH <u>AUGUST 27, 1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 14, 1901</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM HENRY SHORTER</u>		14. MOTHER'S MAIDEN NAME <u>ELSIE JANE BROWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-58-0100</u>	
17. INFORMANT <u>MARY C. JENNIFER</u>		Address <u>MECHANICSVILLE, MARYLAND</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>57</u> , to <u>Aug</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>8-27</u> , 19 <u>67</u> and that death occurred at _____ M, from causes _____ and on the date stated above.			
22a. SIGNATURE <u>Leon W. Berbee</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Leon W. Berbee M.D.</u>		22d. ADDRESS <u>MECHANICSVILLE, MARYLAND</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Aug. 31, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>EBENEZER CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>NEW MARKET, ST. MARY'S, MARYLAND</u>
24. FUNERAL DIRECTOR <u>W. CLARKE MATTINGLEY</u>		25a. REC'D BY REGISTRAR <u>AUG 31 1967</u>	
ADDRESS <u>LEONARDTOWN, MARYLAND</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

1154

CERTIFICATE OF DEATH

REPORT OF DEATH

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

HEIGHT

WEIGHT

COMPLEXION

HAIR

DOB

DATE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

RESIDENCE

DECEASED'S NAME

DECEASED'S ADDRESS

DATE OF DEATH

1154

DECEASED'S NAME

DECEASED'S NAME

DECEASED'S ADDRESS

DECEASED'S ADDRESS

DECEASED'S ADDRESS

DECEASED'S ADDRESS

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11520

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11525

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Mary's Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Invin</u> Last <u>Tippett</u>			4. DATE OF DEATH Month <u>August</u> Day <u>2</u> Year <u>1967</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 20, 1917</u>		9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>James O. Tippett</u>				14. MOTHER'S MAIDEN NAME <u>Gertrude Buckler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-30-6852</u>		17. INFORMANT <u>Mary Frances Tippett</u> Address <u>Avenue, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Coronary Infarction</u> 4201 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>  </u> <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>W.D. Boyd</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>William D. Boyd M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				22. DATE SIGNED <u>8/4/67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug. 5, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Bushwood, St. Mary's, Md.</u>	
24. FUNERAL DIRECTOR <u>W. Clarke Mattingley</u>				25a. REC'D BY REGISTRAR   25b. REGISTRAR'S SIGNATURE DATE <u>AUG 7 1967</u> <u>J. Charles Judge</u>			

1. The first part of the report is a general statement of the work done during the year. It is a summary of the work done by the various departments of the institution, and is intended to give a general idea of the progress of the work.

2. The second part of the report is a detailed statement of the work done by each of the departments. It is a summary of the work done by each of the departments, and is intended to give a detailed idea of the progress of the work.

3. The third part of the report is a statement of the financial condition of the institution. It is a summary of the financial condition of the institution, and is intended to give a detailed idea of the financial condition of the institution.

4. The fourth part of the report is a statement of the personnel of the institution. It is a summary of the personnel of the institution, and is intended to give a detailed idea of the personnel of the institution.

5. The fifth part of the report is a statement of the property of the institution. It is a summary of the property of the institution, and is intended to give a detailed idea of the property of the institution.

6. The sixth part of the report is a statement of the income of the institution. It is a summary of the income of the institution, and is intended to give a detailed idea of the income of the institution.

7. The seventh part of the report is a statement of the expenditures of the institution. It is a summary of the expenditures of the institution, and is intended to give a detailed idea of the expenditures of the institution.

8. The eighth part of the report is a statement of the assets of the institution. It is a summary of the assets of the institution, and is intended to give a detailed idea of the assets of the institution.

9. The ninth part of the report is a statement of the liabilities of the institution. It is a summary of the liabilities of the institution, and is intended to give a detailed idea of the liabilities of the institution.

10. The tenth part of the report is a statement of the net worth of the institution. It is a summary of the net worth of the institution, and is intended to give a detailed idea of the net worth of the institution.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
11521 CERTIFICATE OF DEATH 11526										
1. PLACE OF DEATH a. COUNTY <i>St. Mary's</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>St. Mary's</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Leonardtown</i>				c. LENGTH OF STAY IN 1b <i>3 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Loveville</i> <i>18-1</i>			d. STREET ADDRESS <i>Rt. 2 Box 144A</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>St. Mary's Hospital</i>					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <i>Maggie</i> Middle <i>Stahl</i> Last <i>Zimmerman</i>			4. DATE OF DEATH Month <i>August</i> Day <i>13</i> Year <i>1967</i>							
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept. 8, 1909</i>		9. AGE (In years last birthday) <i>57</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (County & State, or foreign country) <i>Penna.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>John Fox</i>					14. MOTHER'S MAIDEN NAME <i>Elizabeth Stahl</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Monroe Zimmerman</i> Address <i>Rt. 2 Box 144A Leonardtown, Maryland</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>153 Acute Cardiovascular collapse</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Intestinal obstruction</i> (c) <i>Carcinoma of the Colon</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Maryland</i> INTERVAL BETWEEN ONSET AND DEATH										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.										
22a. SIGNATURE <i>A. Samadi</i>					22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <i>A. SAMADI M. D.</i>					22d. ADDRESS <i>LEONARDTOWN, MARYLAND</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>Aug. 16, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mennonite Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Loveville St. Mary's Md.</i>			
24. FUNERAL DIRECTOR <i>W. Clarke Mattingley Leonardtown, Maryland</i>					25a. REC'D BY REGISTRAR <i>AUG 18 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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